STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS HEALTH AND REHAB CENTER	10352 N 600 E COUNTY LINE RD DEMOTTE, IN46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00089789 & IN 00089888. Complaint IN00089789 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F309. Complaint IN00089888 - Substantiated. Federal/state deficiencies related to the allegations are cited at F281, F282, and F329. Survey dates: May 24 & May 25, 2011 Facility number: 000471 Provider number: 155572 AIM number: 100290390 Survey team: Kathleen (Kitty) Vargas, RN, TC Janet Adams, RN Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 13 Medicaid: 42 Other: 12 Total: 67	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/1/11 by Jennie Bartelt, RN.			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

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	Based on observation, record review and interview, the facility failed to ensure the physician was notified related to the need for post-operative surgical wound care for 1 of 3 residents reviewed for surgical wound care. (Resident #F) The facility also failed to ensure the physician was notified related to the need for care of cardiac pacemakers for 2 of 3 residents with cardiac pacemakers in a sample of 8. (Residents # B & #J) Findings include: 1. On 5/24/11 at 10:10 a.m., during orientation tour, Resident #F was observed in bed. The Nurse Consultant indicated, at that time, that the resident had recently been admitted to the facility after an amputation of the lower extremity. On 5/24/11 at 2:45 p.m. the resident was seated in a wheelchair in front of the nurses' station. The resident had an amputation of his left leg. The amputation site was not covered with a dressing or a wrap. On 5/25/11 at 2:20 p.m., the resident was observed in the therapy room seated in a wheelchair. The surgical wound on the left lower extremity was observed to have staples in place, there was no dressing or	F0157	F157 I. Resident F: Orders were received for removal of staples on 5/25/11 and they were removed. Surgeon was notified and stated that no follow up visit or care was needed. Surgical site assessed, edges were well approximated and there were no signs of infection noted. Resident B has been discharged from this facility. Resident J we have requested pacemaker records and pacemaker settings from the hospital. Physician notified of need for pacemaker follow up, pacemaker check will be scheduled. II. All residents admitted in the past thirty days were reviewed to ensure that any surgical wounds follow up was completed. Any wound care follow up that was needed has been completed. Physicians notified as indicated. All residents in facility have been assessed to identify those with pacemakers. Medical record to be reviewed to identify presence of pacemaker and pacemaker settings. Pacemaker checks have been scheduled as indicated. Physicians notified as indicated. III. In-service for licensed staff on Pacemaker Policy and monitoring of pacemaker function completed 6/9/11.	06/24/2011

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	wrap on the surgical site. Interview with LPN #1 on 5/2/11 at 12:00 p.m. indicated there was no treatment ordered for the resident's amputation site. The record for Resident #F was reviewed on 5/25/11 at 1:40 p.m. The resident was admitted to the facility on 5/12/11. The resident had diagnoses that included, but were not limited to, left above the knee amputation, congestive heart failure, peripheral vascular disease, and hypertension. The hospital discharge summary, dated 5/9/11, indicated the resident had an above the knee amputation of his left lower extremity on 4/26/11. The Admission/Readmission Nursing Assessment dated 5/12/11 indicated the resident had a left above the knee amputation. The surgical wound had 29 staples intact and was 18 centimeters in length. Review of the admission physician orders, dated 5/12/11, indicated there were no orders for care of the surgical wound. There were no physician orders for a dressing, no removal date for the staples, no orders for a return visit to the surgeon and no orders for stump care for		In-service for licensed staff on surgical wound care and follow up care (treatments, follow up visits, staple/suture removal) was completed 6/9/11 IV. Admissions and Re-admission orders will be reviewed by the DON or designee within 24-72 hours to ensure that all pertinent treatment orders related to surgical wound care and follow up appointments are present and scheduled. All Admissions and Re-admissions will be reviewed for pacemaker placement, and if pacemaker is present will ensure documentation of settings, and frequency of pacemaker checks are recorded on the physician order sheet. Frequency of pacemaker checks will also be recorded on the Treatment Administration Record. Audit results will be reviewed in QA monthly for 3 months then quarterly x2. V. Correction Date 6/24/2011	

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	prosthetic fitting. The physician's orders dated 5/12/11 through 5/25/11 were reviewed. There were no physician orders related to staple removal or post-operative care. The nursing progress notes dated 5/12/11 through 5/25/11 were reviewed. There was no documentation of any attempts to notify the attending physician or the surgeon of the need for post-operative orders for the care of the surgical wound. There was no documentation that the attending physician or the surgeon was notified of the need to obtain a date for removal of the staples. Interview with the Nurse Consultant on 5/25/11 at 3:15 p.m. indicated the resident had staples in his amputation site, 29 days after the surgery. The Nurse Consultant indicated the attending physician and/or the surgeon should have been notified that orders for the removal of the staples and for post-operative care of the surgical wound were needed. 2. The closed record for Resident #B was reviewed on 5/25/1 at 1:00 p.m. The resident was admitted to the facility on 7/2/08. The resident had diagnoses that included, but were not limited to, dementia, depression, pacemaker and			

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	atrial fibrillation. The quarterly MDS (Minimum Data Set) assessment, completed on 2/4/11, indicated the resident had a cardiac pacemaker in place. Review of the form titled "Physician Certification for Long-Term Care Services" that was dated 7/1/08 indicated the resident's primary diagnosis was cardiac pacemaker placement. The form titled "Care Plan Conference Summary " and dated 7/17/08, indicated the resident's goal was long-term care, it also indicated the cardiologist was to be notified for Post Care. Review of the medical record indicated there was no physician's order for pacemaker battery check. There was no documentation that the function of the resident's pacemaker had been checked. The policy titled, "Care of Resident with a Permanent Cardiac Pacemaker" was provided by the Nurse Consultant on 5/25/11. The policy was revised on 9/2005. She indicated the policy was current. The policy indicated: Obtain order for periodic pacemaker battery check. Special equipment required			

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	or procedure may be done via telephone to physician's office or pacemaker clinic. An alternate may be an ECG (electrocardiogram) which is transmitted via special phone equipment. Normal battery life is approximately 30-60 months. The resident was discharged to another skilled nursing facility on 2/11/11, and review of the discharge summary instructions indicated no instructions for cardiac pacemaker checks. Interview with the Nurse Consultant on 5/25/11 at 8:45 a.m. indicated there was no documentation that periodic pacemaker battery checks were completed for the resident during her stay at the facility from 7/2/08 through 2/11/11. She also indicated there was no documentation that the physician was notified of the need for orders related to monitoring the function of the pacemaker as required by facility policy. 3. On 5/24/11, the facility provided a list of residents who had cardiac pacemakers. Resident #J was listed as having a cardiac pacemaker. The record for Resident #J was reviewed on 5/25/11 at 9:00 a.m. The resident was admitted to the facility on 3/4/09. The			

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	resident had diagnoses that included, but were not limited to, sinus node dysfunction, cardiovascular disease, and vascular dementia with psychotic features. The quarterly MDS, completed on 5/4/11, indicated the resident had a cardiac pacemaker. The physician's orders were reviewed. There were no physician's order for pacemaker battery check. Review of the care plan initiated on 2/8/11 indicated the resident has altered cardiovascular status related to congestive heart failure, hypertension, arrhythmia and coronary artery disease. There was no indication on the care plan of a cardiac pacemaker or the need for periodic pacemaker battery checks. Interview with the Nurse Consultant on 5/25/11 at 2:05 p.m. indicated that she had spoken to the resident's daughter. The resident's daughter stated the resident had the pacemaker for three years prior to being admitted to the facility. She stated that she gave information to the facility staff regarding the pacemaker checks some time ago. She stated that she knew the facility had performed a pacemaker check using the telephone at least one time.			

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	Continued interview with the Nurse Consultant on 5/25/11 at 2:05 p.m. indicated there was no documentation that the physician was notified of the need for orders related to monitoring the function of the resident's pacemaker. This federal tag relates to Complaint #IN00089789. 3.1-5(a)(3)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to provide professional standards of quality related to not following the five rights of medication administration for 1 of 1 resident in the sample of 8 who received a medication that had been discontinued by the Physician. (Resident #D) (LPN #1) Findings include: The Drug Administration Guidelines in the 2010 Nursing Spectrum Drug Handbook indicated nurses were to apply the "five rights" of drug administration when administering medications. The	F0281	F281 I. Resident D had no adverse effects from the medication error made on 4/23/11. Medication error form had been previously completed prior to survey and physician and family were notified. II. Completed review of medication and treatment records for the last 30 days to ensure that changes in orders are clearly marked and that medications have been administered as ordered. Medication Error reports have been completed and physicians notified as indicated.	06/24/2011

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	five rights were as follows: Right Patient Right Drug Right Dose Right Time Right Route Guidelines for the administration of the right drug include to match the drug label against the order on the Medication Administration Record. The record for Resident #D was reviewed on 5/24/11 at 12:15 p.m. The resident was admitted to the facility on 3/1/11. Physician's orders obtained on 3/1/11 indicated the resident was to receive Ativan (an anitanxiety medication) 0.5 milligrams twice a day. A Physician's order was written on 4/21/11 to discontinue the Ativan. Review of the 4/11 Medication Administration Record indicated the resident received the Ativan twice a day 4/1/11 through 4/20/11. There was writing in the Medication Administration Record on the line for signing out the medication that the medication was discontinued on 4/21/11. The line was highlighted yellow also at the time of the review. The medication was signed out as given on 4/23/11 at 8:00 a.m. A Medication Error Report" dated		III. Licensed nurses and QMA's have been re-educated on Rights of Medication Administration, Policy on Medication Errors/Reports, Medication Discontinuation and Disposition, Verification of physician orders if the order on the MAR/TAR are unclear, and Notification of Physician and DON. IV. Telephone orders and Medication and Treatment Administration Records will be reviewed a minimum of three times per week to ensure accuracy of records. DON or designee will do at least 5 medication pass observations per week on varied shifts. The results of these audits and observations will be reviewed monthly in QA for 3 months then quarterly x2. V. Correction Date: 6/24/2011	

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	4/25/11 was reviewed. The report indicated Resident #D received a dose of Ativan at 8:00 a.m. on 4/23/11 after the Ativan had been discontinued. The report indicated the error was discovered after the medication was given and the resident's husband let the Nurse know the Ativan was to have been discontinued. The report also indicated the "Medication Book" was circled as the source of information regarding the medication given. "Chart" was not circled. The "Type of Error" was marked as "Wrong Medication" When interviewed on 5/24/11 at 3:10 p.m., LPN #1 indicated she had administered a dose of Ativan to Resident #D on 4/23/11 at 8:00 a.m. The LPN indicated the Ativan previously had been ordered to be given at 8:00 a.m. and 8:00 p.m. The LPN indicated there was writing in the Medication Administration record indicating it was to be discontinued but at the time she felt that writing was pertinent only to the 8:00 p.m. dose and not the 8:00 a.m. The LPN indicated the Ativan had not been highlighted yellow as discontinued medications usually are. LPN #1 indicated she did not look at the Physician's orders at that time. LPN#1 indicated the oncoming evening shift Nurse came in at 2:00 p.m. and the oncoming Nurse indicated both doses of			

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	the Ativan were to have been discontinued. LPN #1 indicated she did not fill out a Medication Error Report at that time. The LPN indicated this occurred on a weekend shift and she did not notify the Director of Nursing until she returned to work on Monday. When interviewed on 5/24/11 at 3:50 p.m., the Director of Nursing indicated nursing staff were to complete an Medication Error Report when the error is made. The Director of Nursing indicated a medication error was made when Resident #D received a dose of Ativan on 4/23/11 after Physician orders were written on 4/21/11 to discontinue the medication. This federal tag relates to Complaint IN00089888. 3.1-35(g)(1)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow physician's orders related to the administration of a medication after the physician ordered the medication to be discontinued for 1 of 1 resident reviewed related to discontinued medications being administered in a sample of 8, who received a medication in error. (Resident #D) (LPN #1) Findings include: The record for Resident #D was reviewed on 5/24/11 at 12:15 p.m. The resident was admitted to the facility on 3/1/11. Physician's orders obtained on 3/1/11 indicated the resident was to receive Ativan (an anitanxiety medication) 0.5 milligram twice a day. A Physician's order was written on 4/21/11 to discontinue the Ativan. Review of the 4/11 Medication Administration Record indicated the resident received the Ativan twice a day 4/1/11 through 4/20/11. There was writing in the Medication Administration	F0282	F282 I. Resident D had no adverse effects from the medication error made on 4/23/11. Medication error form had been previously completed prior to survey and physician and family were notified. II. Completed review of medication and treatment records for the last 30 days to ensure that changes in orders are clearly marked and that medications have been administered as ordered. Medication Error reports have been completed and physicians notified as indicated. III. Licensed nurses and QMA's have been re-educated on Rights of Medication Administration, Policy on Medication Errors/Reports, Medication Discontinuation and Disposition, Verification of physician orders if the order on the MAR/TAR are unclear, and Notification of Physician and DON. IV. Telephone orders and Medication and Treatment Administration Records will be reviewed a minimum of three	06/24/2011

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	Record on the line for signing out the medication that the medication was discontinued on 4/21/11. The line was highlighted yellow also at the time of the review. The medication was signed out as given on 4/23/11 at 8:00 a.m. A Medication Error Report" dated 4/25/11 was reviewed. The report indicated Resident #D received a dose of Ativan at 8:00 a.m. on 4/23/11 after the Ativan had been discontinued. The report indicated the error was discovered after the medication was given and the resident's husband let the Nurse know the Ativan was to have been discontinued. The report also indicated the "Medication Book" was circled as the source of information regarding the medication given. "Chart" was not circled. The "Type of Error" was marked as "Wrong Medication" When interviewed on 5/24/11 at 3:10 p.m., LPN #1 indicated she had administered a dose of Ativan to Resident #D on 4/23/11 at 8:00 a.m. The LPN indicated the Ativan had previously been ordered to given at 8:00 a.m. and 8:00 p.m. The LPN indicated there was writing in the Medication Administration record indicating it was to be discontinued but at the time she felt that writing was pertinent only to the 8:00 p.m. dose and		times per week to ensure accuracy of records. DON or designee will do at least 5 medication pass observations per week on varied shifts. The results of these audits and observations will be reviewed monthly in QA for 3 months then quarterly x2. V. Correction Date: 6/24/2011	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not the 8:00 a.m. When interviewed on 5/24/11 at 3:50 p.m., the Director of Nursing indicated a medication error was made when Resident #D received a dose of Ativan on 4/23/11 after Physician orders were written on 4/21/11 to discontinue the medication. This Federal tag relates to Complaint IN00089888. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure necessary care and services were provided for post-operative care of a surgical wound for 1 of 3 residents reviewed for surgical wound care. (Resident #F) The facility also failed to ensure the monitoring of cardiac pacemaker function was completed for 2 of 3 records reviewed for pacemaker monitoring in a sample of 8. (Residents # B & #J)	F0309	F309 I. Resident F: Orders were received for removal of staples on 5/25/11 and they were removed. Surgeon was notified and stated that no follow up visit or care was needed. Surgical site assessed, edges were well approximated and there were no signs of infection noted. Resident B has been discharged from the facility. Resident J we have requested pacemaker records and	06/24/2011

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	155572	A. BUILDING 00 B. WING	05/25/2011

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	Findings include: 1. On 5/24/11 at 10:10 a.m., during orientation tour, Resident #F was observed in bed. The Nurse Consultant indicated, at that time, that the resident had recently been admitted to the facility after an amputation of the lower extremity. On 5/24/11 at 2:45 p.m. the resident was seated in a wheelchair in front of the nurses' station. The resident had an amputation of his left leg. The amputation site was not covered with a dressing or a wrap. On 5/25/11 at 2:20 p.m., the resident was observed in the therapy room seated in a wheelchair. The surgical wound on the left lower extremity was observed to have staples in place, there was no dressing or wrap on the surgical site. Interview with LPN #1 on 5/2/11 at 12:00 p.m. indicated there was no treatment ordered for the resident's amputation site. The record for Resident #F was reviewed on 5/25/11 at 1:40 p.m. The resident was admitted to the facility on 5/12/11. The resident had diagnoses that included, but were not limited to, left above the knee		pacemaker settings from the hospital. Physician notified of need for pacemaker follow up, pacemaker check will be scheduled. II. All residents admitted in the past thirty days were reviewed to ensure that any surgical wounds follow up was completed. Any wound care follow up that was needed has been completed. Physicians notified as indicated. All residents in facility have been assessed to identify those with pacemakers. Medical record to be reviewed to identify presence of pacemaker and pacemaker settings. Pacemaker checks have been scheduled as indicated. Physicians notified as indicated. III. In-service for licensed staff on Pacemaker Policy and monitoring of pacemaker function completed 6/9/11. In-service for licensed staff on surgical wound care and follow up care (treatments, follow up visits, staple/suture removal) was completed 6/9/11 IV. Admissions and Re-admission orders will be reviewed by the DON or designee within 24-72 hours to ensure that all pertinent treatment orders related to surgical wound care and follow up appointments are present and scheduled. All Admissions and Re-admissions	

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	amputation, congestive heart failure, peripheral vascular disease, and hypertension. The hospital discharge summary, dated 5/9/11, indicated the resident had an above the knee amputation of his left lower extremity on 4/26/11. The Admission/Readmission Nursing Assessment dated 5/12/11 indicated the resident had a left above the knee amputation. The surgical wound had 29 staples intact and was 18 centimeters in length. Review of the admission physician orders, dated 5/12/11, indicated there were no orders for care of the surgical wound. There were no physician orders for a dressing, no removal date for the staples, no orders for a return visit to the surgeon and no orders for stump care for prosthetic fitting. The physician's orders dated 5/12/11 through 5/25/11 were reviewed. There were no physician orders related to staple removal or post-operative care. The nursing progress notes dated 5/12/11 through 5/25/11 were reviewed. There was no documentation of any attempts to contact the attending physician or the		will be reviewed for pacemaker placement, and if pacemaker is present will ensure documentation of settings, and frequency of pacemaker checks are recorded on the physician order sheet. Frequency of pacemaker checks will also be recorded on the Treatment Administration Record. Audit results will be reviewed in QA monthly for 3 months then quarterly x2. V. Correction Date 6/24/2011	

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	surgeon to obtain post-operative orders for the care of the surgical wound. There was no documentation that the attending physician or the surgeon was contacted to obtain a date for removal of the staples. Interview with the Nurse Consultant on 5/25/11 at 3:15 p.m. indicated the resident had staples in his amputation site, 29 days after the surgery. She also indicated there were no orders for the removal of the staples. She indicated staff should have obtained orders for the removal of the staples and for post-operative care of the surgical wound. 2. The closed record for Resident #B was reviewed on 5/25/1 at 1:00 p.m. The resident was admitted to the facility on 7/2/08. The resident had diagnoses that included, but were not limited to, dementia, depression, pacemaker and atrial fibrillation. The quarterly MDS (Minimum Data Set) assessment, completed on 2/4/11, indicated the resident had a cardiac pacemaker in place. Review of the form titled "Physician Certification for Long-Term Care Services" that was dated 7/1/08 indicated the resident's primary diagnosis was cardiac pacemaker placement.			

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The form titled "Care Plan Conference Summary " and dated 7/17/08, indicated the resident's goal was long-term care, it also indicated the cardiologist was to be notified for Post Care.

Review of the medical record indicated there was no physician's order for pacemaker battery check. There was no documentation that the function of the resident's pacemaker had been checked.

The policy titled, "Care of Resident with a Permanent Cardiac Pacemaker" was provided by the Nurse Consultant on 5/25/11. The policy was revised on 9/2005. She indicated the policy was current. The policy indicated:

Obtain order for periodic pacemaker battery check. Special equipment required or procedure may be done via telephone to physician's office or pacemaker clinic. An alternate may be an ECG (electrocardiogram) which is transmitted via special phone equipment. Normal battery life is approximately 30-60 months.

The resident was discharged to another skilled nursing facility on 2/11/11, and review of the discharge summary instructions indicated no instructions for

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	cardiac pacemaker checks. Interview with the Nurse Consultant on 5/25/11 at 8:45 a.m. indicated there was no documentation that periodic pacemaker battery checks were completed for the resident during her stay at the facility from 7/2/08 through 2/11/11. She also indicated there were no physician orders related to monitoring the function of the pacemaker as required by facility policy. 3. On 5/24/11, the facility provided a list of residents who had cardiac pacemakers. Resident #J was listed as having a cardiac pacemaker. The record for Resident #J was reviewed on 5/25/11 at 9:00 a.m. The resident was admitted to the facility on 3/4/09. The resident had diagnoses that included, but were not limited to, sinus node dysfunction, cardiovascular disease, and vascular dementia with psychotic features. The quarterly MDS, completed on 5/4/11, indicated the resident had a cardiac pacemaker. The physician's orders were reviewed. There were no physician's order for pacemaker battery check.			

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	Review of the care plan initiated on 2/8/11 indicated the resident has altered cardiovascular status related to congestive heart failure, hypertension, arrhythmia and coronary artery disease. There was no indication on the care plan of a cardiac pacemaker or the need for periodic pacemaker battery checks. Interview with the Nurse Consultant on 5/25/11 at 2:05 p.m. indicated that she had spoken to the resident's daughter. The resident's daughter stated the resident had the pacemaker for three years prior to being admitted to the facility. She stated that she gave information to the facility staff regarding the pacemaker checks some time ago. She stated that she knew the facility had performed a pacemaker check using the telephone at least one time. Continued interview with the Nurse Consultant on 5/25/11 at 2:05 p.m. indicated there were no physician's orders related to monitoring the function of the resident's pacemaker. She indicated the facility policy for the care of residents with a cardiac pacemaker had not been followed. This federal tag relates to Complaint #IN00089789.			

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	3.1-37(a)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review, and interview, the facility failed to ensure the resident's drug regime was free of unnecessary drugs related to the lack of indication for the use of and on going monitoring for the continued use of an antianxiety medication for 1 of 3 residents reviewed for the use of anitanxiety medication use in the sample of 8. (Resident #D)	F0329	F329 I. Ativan for Resident D was discontinued on 4/21/2011 II. Audit of all psychotropic medications completed to ensure appropriate diagnosis or indication for use and appropriate monitoring is present for each medication. III. All admission/re-admission	06/24/2011

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	Findings include: On 5/24/11 at 11:35 a.m., Resident #D was observed in bed. The resident was awake and calm. On 5/24/11 at 12:55 p.m., the resident was resident was observed sitting in a wheel chair in the Dining Room. The resident was being fed her lunch. The resident was quiet at this time. The resident was not displaying any behaviors at the above times. On 5/25/11 at 8:30 a.m., the resident was observed in a wheelchair. The resident was awake and quiet. The resident was being wheeled into her room by a staff member. On 5/25/11 at 9:45 a.m., the resident was observed asleep in her bed. The resident was not displaying any behaviors at the above times. The record for Resident #D was reviewed on 5/24/11 at 12:15 p.m. The resident was admitted to the facility on 3/1/11 from the hospital. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), high blood pressure, and anemia. There was no diagnosis of anxiety in the the resident's record at this time. Review of a History and Physical report completed by the Physician while the resident was hospitalized indicated the resident was admitted to the hospital on 2/24/11.		medication orders will be reviewed upon admission to ensure appropriate diagnosis and/or indication for use and monitoring are present. Social Service and pharmacist will review psychotropic medications monthly to ensure diagnosis and/or indication for use and monitoring are appropriate and ongoing. They will make recommendations for gradual dose reductions as indicated. In-service for licensed staff completed for documentation for behaviors, behavior management plans and obtaining appropriate diagnosis or indication for each medication, and monitoring for side effects and effectiveness. IV. Audits will be reviewed monthly in QA for three months then quarterly x two. V. Correction Date 6/24/2011	

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	There was no diagnosis of anxiety noted in the History and Physical report. The resident's home medications listed in the History and Physical did not include any antianxiety medications. The facility policy titled "Psychopharmacological Medications" was received from the Nurse Consultant on 5/25/11 at 1:15 p.m. and identified as the current policy. There was no date on the policy. The policy was reviewed at this time. The policy indicated the facility was to "evaluate each resident regarding the use of psychopharmacological medication." The policy also indicated the overall efficacy of the medications was to be monitored through the care planning process and include supporting diagnoses for the medication and exhibited behaviors which warranted the use of the medication. Review of the 3/1/11 Physician orders indicated there was an order for the resident to receive Ativan (an antianxiety medication) 0.5 milligrams twice a day. An order was written on 4/13/11 to change the times the Ativan was to be given from 7:00 a.m. and 4:00 p.m. to 8:00 a.m. and 8:00 p.m. An order was written on 4/21/11 to discontinue the Ativan.			

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	The 3/8/11 Minimum Data Set (MDS) admission assessment indicated the resident had not displayed any physical or verbal behaviors towards others. The MDS assessment indicated the resident was receiving an antianxiety medication and did not have an active diagnosis of Anxiety Disorder. Physician Progress Notes completed on 3/1/11 and 4/11/11 indicated there was no diagnoses of anxiety or aggressive resident behaviors. The Nurses' Notes from 3/1/11 thru 4/19/11 indicated there was no documentation of the resident displaying an signs of anxiety or aggressive behaviors. The resident's care plans were reviewed. There were no care plans in place related to the resident displaying any anxious or aggressive behaviors. Social Service Progress Notes from 3/1/11 though 4/21/11 were reviewed. There was no documentation of the resident receiving Ativan twice a day during this time. There was no documentation of the resident displaying any aggressive behaviors or diagnosis of anxiety. A Consultation Report was completed by the facility's pharmacy on 4/11/11. The report indicated there was no diagnosis to			

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	support the continued use of the Ativan 0.5 milligrams twice a day. When interviewed on 5/25/11 at 10:20 a.m., the Social Worker indicated Resident #D was receiving Ativan when she was admitted and the medication was discontinued on 4/21/11 after the family voiced concerns with the resident being sleepy and that was affecting her therapy. When interviewed on 5/25/11 at 12:30 p.m., the Director of Nursing indicated the resident had orders to receive Ativan when she was admitted to the facility in 3/2011. The Director indicated there was no diagnosis for the use of the antianxiety medication. When interviewed on 5/25/11 at 2:45 p.m., the Director of Nursing indicated the resident had been receiving Ativan from 3/1/11 through 4/21/11. The Director of Nursing indicated there had been no diagnosis for the continued use of the Ativan. The Director of Nursing indicated there was no documentation of behaviors or monitoring to indicate the continued need of the medication. This federal tag relates to Complaint IN00089888. 3.1-48(a)(3)			

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